UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF CALIFORNIA

WALDO RENE MEDINA,

Plaintiff,

v.

CAROLYN W. COLVIN, Acting Commissioner of Social Security,

Defendant.

Case No.: 16cv215-GPC(KSC)

REPORT AND RECOMMENDATION RE:

(1) CROSS-MOTIONS FOR SUMMARY JUDGMENT [Doc. Nos. 26 and 32];

(2) DEFENDANT'S MOTION TO DISMISS [Doc No. 25];

(3) PLAINTIFF'S MOTION TO EXCLUDE EVIDENCE [Doc. No. 30]; AND

(4) PLAINTIFF'S EX PARTE REQUEST TO SUPPLEMENT THE RECORD [Doc. No. 28]

Pursuant to Title 42, United States Code, Section 405(g), of the Social Security Act ("SSA"), plaintiff filed a Complaint to obtain judicial review of a final decision by the Commissioner of Social Security ("Commissioner") denying him disability insurance benefits.[1] [Doc. No. 1.] Although plaintiff was represented by counsel while his disability claim was pending before the Commissioner, he is unrepresented in this action and is proceeding *in forma pauperis*.[2] [Doc. No. 6.]

Presently before the Court are: (1) defendant's Motion for Involuntary Dismissal [Doc. No. 25]; (2) defendant's Motion for Summary Judgment [Doc. No. 26]; (3) plaintiff's Ex Parte Request to Supplement the Administrative Record [Doc. No. 28]; (4) plaintiff's Motion to Exclude Evidence [Doc. No. 30]; (5) plaintiff's Motion for Summary Judgment [Doc. No. 32]; (6) defendant's Response to plaintiff's Motions [Doc. No. 33]; (7) plaintiff's Response to defendant's Motion for Summary Judgment; and (8) the Administrative Record ("AR") [Doc. No. 10].

After careful consideration of the moving and opposing papers, as well as the Administrative Record and the applicable law, it is RECOMMENDED that the District Court affirm the ALJ's decision to deny benefits by issuing an order DENYING defendant's Motion for Involuntary Dismissal; GRANTING defendant's Motion for Summary Judgment; DENYING plaintiff's Motion for Summary Judgment; DENYING

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[1] Title 42, United States Code, Section 405(g), provides as follows: "Any individual, after any final decision of the Commissioner of Social Security made after a hearing to which he was a party . . . may obtain a review of such decision by a civil action . . . brought in the district court of the United States. . . . The court shall have power to enter, upon the pleadings and transcript of the record, a judgment affirming, modifying, or reversing the decision of the Commissioner of Social Security, with or without remanding the cause for a rehearing. The findings of the Commissioner . . . as to any fact, if supported by substantial evidence, shall be conclusive. . . ." 42 U.S.C. §405(g).

[2] District Courts are obligated to afford a certain amount of leeway to *pro se* litigants and to construe their pleadings liberally. *Hebbe v. Pliler*, 627 F.3d 338, 342 (9th Cir. 2010).

plaintiff's Motion to Exclude Evidence; and DENYING plaintiff's Ex Parte Request to Supplement the Administrative Record.

I. Background and Procedural History.

On December 9, 2011, plaintiff applied for disability benefits claiming he was unable to work as of August 10, 2002. [AR 180-181.] At this time, plaintiff reported that he lived in a home or apartment and did not need help with personal care, hygiene, upkeep of a home, or cooking. [AR 185.]

On January 23, 2014, plaintiff was notified that his application had been reviewed, but he did not qualify for disability benefits because his medical condition was not severe enough to prevent him from working. [AR 90-94.] Plaintiff requested reconsideration of this decision, but his request for benefits was denied once again on April 30, 2014. [AR 98-102.] On June 22, 2014, plaintiff requested a hearing before an Administrative Law Judge ("ALJ"). [AR 104-105.] A hearing was held on January 6, 2015. [AR 33, 126-165.]

On January 27, 2015, the ALJ concluded that plaintiff was not disabled within the meaning of the SSA and did not qualify for disability insurance benefits. [AR 19-28.] Plaintiff requested review of the ALJ's decision by the Appeals Council. [AR 16.] After considering additional evidence in the form of a representative brief, the Appeals Council denied review of the ALJ's decision on July 13, 2015. [AR 1-5.] If the Appeals counsel denies review, the decision of the ALJ becomes the final decision of the Commissioner. 20 C.F.R. § 404.981. The Complaint in this action was then filed on September 3, 2015 seeking review of the Commissioner's final decision. [Doc. No. 1.]

II. Defendant's Motion to Dismiss.

On October 19, 2016, defendant filed a Motion for Involuntary Dismissal for Failure to Prosecute and for Failing to Follow This Court's Amended Scheduling Order. [Doc. No. 25.] In the Motion, defendant cited Federal Rule of Civil Procedure 41(b) and argued that the action should be dismissed without a determination on the merits for failure to prosecute, because plaintiff failed to comply with briefing orders that set a

schedule for the parties to file cross-motions for summary judgment. [Doc. No. 25-1, at pp. 2-3.]

Rule 41(b) authorizes an involuntary dismissal "[i]f the plaintiff fails to prosecute or to comply with [the Federal Rules] or a court order. . . ." Fed.R.Civ.P. 41(b). However, dismissal under Rule 41(b) "is so harsh a penalty it should be imposed as a sanction only in extreme circumstances." *Lal v. California*, 610 F.3d 518, 525 (9th Cir. 2010), quoting *Dahl v. City of Huntington Beach*, 84 F.3d 363, 366 (9th Cir.1996).

Here, based on a review the docket, it is apparent that plaintiff, who is prosecuting this case *pro se*, did not proceed exactly as directed in the Court's briefing orders and ***may*** have neglected to serve defense counsel with some of the moving papers he submitted to the Court for filing. Plaintiff's actions resulted in some confusion and a brief delay in getting the case fully briefed for the Court's consideration. [Doc. Nos. 13-36.] These are hardly the type of "extreme circumstances" that would justify an involuntary dismissal under Rule 41(b). It is therefore RECOMMENDED that the District Court DENY defendant's Motion for Involuntary Dismissal and consider plaintiff's Complaint on the merits. [Doc. No. 25.]

III. Standards of Review – Final Decision of the Commissioner.

The final decision of the Commissioner must be affirmed if it is supported by substantial evidence and if the Commissioner has applied the correct legal standards. *Batson v. Comm'r of the Social Security Admin.*, 359 F.3d 1190, 1193 (9th Cir. 2004). Under the substantial evidence standard, the Commissioner's findings are upheld if supported by inferences reasonably drawn from the record. *Id.* If there is evidence in the record to support more than one rational interpretation, the District Court must defer to the Commissioner's decision. *Id.* "Substantial evidence means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Osenbrock v. Apfel*, 240 F.3d 1157, 1162 (9th Cir. 2001). "In determining whether the Commissioner's findings are supported by substantial evidence, we must consider the evidence as a whole, weighing both the evidence that supports and the evidence that

detracts from the Commissioner's conclusion." *Smolen v. Chater*, 80 F.3d 1273, 1279 (9th Cir. 1996).

Pursuant to Federal Rule of Civil Procedure 56(a), "[t]he court shall grant summary judgment if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed.R.Civ.P. 56(a). "Summary judgment motions, as defined by Fed.R.Civ.P. 56, contemplate the use of evidentiary material in the form of affidavits, depositions, answers to interrogatories, and admissions. In Social Security appeals, however, the Court may 'look no further than the pleadings and the transcript of the record before the agency,' and may not admit additional evidence. *Morton v. Califano*, 481 F.Supp. 908, 914 n. 2 (E.D. Tenn.1978); 42 U.S.C. § 405(g). Therefore, although summary judgment motions are customarily used [in social security cases], and even requested by the Court or Magistrate, such motions merely serve as vehicles for briefing the parties' positions, and are not a prerequisite to the Court's reaching a decision on the merits." *Kenney v. Heckler*, 577 F.Supp. 214, 216 (N.D. Ohio 1983).

IV. Evidence in the Administrative Record.

A. Forms Submitted by Plaintiff to Support His Disability Claim.

A Disability Report prepared at the time plaintiff submitted his application states that his ability to work is limited by the following conditions: (1) injury to left elbow and right leg/knee; (2) shattered tibia and fibula (two steel plates); (3) transplanted anterior crustate ligament with shattered tibia; (4) shattered radius and ulna (two more steel plates); and (5) "Turrets" possibly due to anesthesia from broken leg surgery. [AR 197-198.] The Disability Report also states that plaintiff has an Associate Degree in architecture that he completed in June 1989. [AR 199.] The examiner who conducted a face-to-face interview with plaintiff on December 9, 2011 noted that plaintiff did not appear to have any difficulty hearing, reading, writing, understanding, speaking, concentrating, sitting, standing, walking, or using his hands. [AR 207.]

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On February 4, 2012, plaintiff submitted a Work History Report stating that he had worked as a clerk in a medical office from 1980 through August 2002 and as a laser technician from September 1989 through May 1993. [AR 209.] As a clerk in a medical office, plaintiff indicated he transcribed doctors' voice recordings of medical files, answered telephones, and retrieved files. [AR 210.] This job also involved sitting for six to seven hours each work day and lifting and carrying expired file boxes weighing 20 to 30 pounds about once or twice per month. [AR 210.] Plaintiff's job as a laser technician required him to repair laser printers at six or seven different sites per day. He lifted and carried laser printers weighing about 20 to 75 pounds about three to four times per work day. In this job, plaintiff was required to stand about seven hours per day. [AR 211-212.] Because of "apparent nerve damages" in his left elbow, plaintiff stated in his Work History Report that he can only type for 20 to 30 minutes before it becomes too painful. [AR 220.] On "rare occasions," plaintiff suffers from "Turrets" caused by anesthesia. [AR 220.]

In a later Disability Report submitted on June 22, 2012, plaintiff stated that the condition of his knee was getting worse, and it had become too painful to walk, so he had to use his bike as a walker when shopping. [AR 242.] At this time, plaintiff also complained that he was examined at Seagate Medical Group in connection with his disability claim, but the doctor did not review prior relevant medical records and did not ask him about pain or other key symptoms. [AR 247-250.]

In another Disability Report, apparently submitted on February 14, 2013, plaintiff reported that the pain in his right knee and shin had increased and he was having difficulty cleaning his home, fixing meals, taking showers, doing laundry, showering, and getting dressed. [AR 267, 270.] He also reported he could no longer walk short distances. [AR 270.]

B. Chronological Summary of Medical Records.

The earliest medical treatment records are from August 21, 2002, and were prepared by Rodney D. Henderson, M.D., ten days after plaintiff had surgery to repair a

"comminuted,[3] right, tibial plateau fracture."[4] [AR 326.] At this time, plaintiff was reportedly "doing well" and was "weaning off Vicodin." [AR 326.] X-rays showed "good alignment at the fracture site" and "hardware in good position." [AR 326.] In addition, Dr. Henderson reported that there was "no pain with passive motion." [AR 326.]

Thereafter, plaintiff had several follow-up appointments with Dr. Henderson. On September 9, 2002, Dr. Henderson's treatment notes state that: "He is doing well. He denies any pain at rest. He does report some sensation of a bone moving when he moves his legs. . . . There is atrophy of the quadriceps. There is really no swelling at the knee at all, and the incision is completely healed. . . . AP and lateral radiographs of the tibia show no change in the hardware position or alignment. There is still a little varus[5] at the proximal fragment, but this is unchanged from the original x-rays." [AR 325.] Dr. Henderson recommended that plaintiff "continue non-weightbearing and gentle range of motion up to 90 degrees as tolerated. . . ." [AR 325.]

On October 14, 2002, two months after surgery, Dr. Henderson reported that plaintiff was "doing well" and "denie[d] any pain." [AR 324.] At this time, Dr. Henderson indicated plaintiff could begin to "toe-touch weight bear, and do straight leg raises and quad sets." [AR 324.] At the time of his follow-up appointment on November 13, 2002, plaintiff reported he had been "trying to bear weight" but was

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[3] "Comminuted" means "a fracture in which the bone is splintered or crushed into numerous pieces." Merriam-Webster Medical Dictionary, http://www.merriam-webster.com/medical/comminuted.

[4] The "tibia" is "the inner and usually larger of the two bones of the vertebrate hind or lower limb between the knee and ankle." Merriam-Webster Dictionary, http://www.merriam-webster.com/dictionary/tibia. The "tibial plateau" is "the smooth bony surface of . . . the tibia . . . ." Merriam-Webster Medical Dictionary, http://www.merriam-webster.com/medical/tibial plateau.

[5] "Varus" means "of, relating to, or being a deformity in which an anatomical part is turned inward toward the midline of the body to an abnormal degree." Merriam-Webster Dictionary, http://www.merriam-webster.com/dictionary/varus.

having some pain in the knee joint. [AR 323.] Dr. Henderson indicated plaintiff could "wean out of the brace," "begin weightbearing," and "use a stationary cycle as tolerated." [AR 323.] Plaintiff continued to progress as indicated in Dr. Henderson's notes dated December 16, 2002 [AR 322]; January 27, 2003 [AR 321]; and March 10, 2003 [AR 320].

Plaintiff had his final follow-up appointment with Dr. Henderson on June 18, 2003, ten months after his surgery. [AR 319.] The treatment notes state that plaintiff "is doing very well and over the last month his symptoms have markedly improved. He denies any pain. His main problem that he reports, which is very minor, is some weakness when he descends stairs. He has been cycling on a daily basis. [¶]His quadracep development has improved. He has full flexion, full extension, and there is no effusion in the knee. Clinically, there is just very mild varus compared to the opposite knee which is also at slight varus. . . . I will release him from my care. I have recommended that he avoid impact loading exercises. He is certainly safer in continuing cycling and swimming. . . ." [AR 319.]

On July 28, 2007, plaintiff went to the emergency room at Scripps Memorial Hospital after he fell off a bicycle and landed on his left side. He had a "significant deformity to his left elbow." [AR 205.] An X-ray revealed "a dislocation of the elbow and radial head, with a fracture of the proximal ulna that is comminuted." [AR 306.] His fracture was "aligned and splinted while he was sedated." [AR 306.] On July 29, 2007, a detailed Operative Report indicates plaintiff had surgery on his left elbow because of a "comminuted unstable Monteggia fracture dislocation." [AR 302-304.] He was discharged on July 31, 2007. [AR 301.] Prior to surgery, plaintiff was advised it was unlikely he would have "return of full range of motion of his elbow and forearm." [AR 309.]

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On August 3, 2007, shortly after the surgery on his elbow, plaintiff went to see Dr. Henderson seeking "reassurance" and a "second opinion." [AR 316.] Plaintiff was known to Dr. Henderson, because he previously operated on plaintiff's knee. [AR 316.] At this time, plaintiff's main concern was that he had been told he "may be at risk for dislocation in the future if his elbow comes out into terminal extension." [AR 316.] Dr. Henderson examined plaintiff and was able to review his x-rays. In addition, Dr. Henderson reviewed postoperative radiographs, which showed "essentially anatomic alignment with internal plate fixation with nice concentric joint alignment." [AR 317.] He reassured plaintiff that his x-rays "look excellent." [AR 317.] Dr. Henderson's written report also states as follows: "Theoretically, he is at risk for possibl[e] dislocation and extension secondary to the comminution of the cornoid fragment; however, in my opinion the more likely scenario would be postoperative stiffness limiting full terminal extension which would most likely prevent any episodes of dislocation." [AR 317.]

Nine days after his surgery, on August 6, 2007, plaintiff had a follow-up appointment with Dr. Hackley. The treatment notes state that plaintiff was "healing nicely." [AR 330.] Dr. Hackley referred plaintiff to physical therapy to "work on range of motion. . . ." [AR 330.] On August 9, 2007, at the next appointment with Dr. Hackley, plaintiff was "doing well" and his wound was "healing nicely." [AR 329.] Dr. Hackley adjusted the brace on plaintiff's arm "to allow him to range from 45 [degrees] to full flexion." [AR 329.] By the next visit on August 20, 2007, plaintiff reported that he had not yet gone to physical therapy. He said he was dealing with some "social issues" and had not had time to see the therapist. [AR 328.] He was still using a brace and the range of motion for his elbow was "30-120 [degrees]." [AR 328.] However, he had a full range of motion in his fingers and wrists. Dr. Hackley encouraged plaintiff to see the physical therapist to work on range of motion exercises. [AR 328.] Six weeks after surgery, on September 10, 2007, Dr. Hackley reported that

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plaintiff was still "doing well" and working on his range of motion. His x-rays showed "further healing" with "[n]o evidence of subluxation[6] on the static views." [AR 327.]

Progress notes dated January 28, 2010 by Denise L. Parnell, M.D., Family Health Centers of San Diego, indicate that plaintiff had a routine medical examination and requested to have a form filled out for food stamps. [AR 379.] During the examination, plaintiff reported that he still had pain in his elbow and leg, and his leg swelled if he walked a mile. [AR 379.] He also said he had Tourette syndrome that was "mostly in remission." [AR 379.]

On September 16, 2010, plaintiff had another routine medical examination at Family Health Centers of San Diego and needed a form filled out for social services. [AR 378.] At this time, plaintiff reported that he could walk a mile before his knee became painful. There was no swelling in his knee or elbow. [AR 378.] His next appointment at Family Health Centers of San Diego was on October 6, 2010. At this time, plaintiff was requesting "disability certification" because of his knee and elbow injuries. [AR 377.] He was not taking any pain medication at this time. [AR 377.] Plaintiff was advised that his records would be requested from Scripps to determine whether he needed "a referral for ortho" and to assess whether he is disabled. [AR 377.] In a later follow-up appointment at Family Health Centers of San Diego on June 24, 2011, plaintiff again requested disability certification for "chronic knee pain" and reported he could walk a half a mile with difficulty. However, the attending physician, Amish Chipwadia, M.D., reviewed plaintiff's "ortho records" and "denied" disability. [AR 375.]

On April 2, 2012, plaintiff appeared for a psychiatric consultative examination by Gregory M. Nicholson, M.D., a Board Certified Psychiatrist. [AR 337-342.] Dr. Nicholson's report says plaintiff's "chief complaint" is anxiety. [AR 337.] Plaintiff

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[6] Subluxation means "partial disclocation (as of one of the bones in a joint)." Merriam-Webster Dictionary, http://www.merriam-webster.com/dictionary/subluxation.

told Dr. Nicholson that he lives alone, and his activities of daily living include cooking and laundry. He had no difficulty with dressing, bathing, or personal hygiene. Although he did not drive because he did not have a vehicle, he was able to go out alone. He was able to handle cash and bills appropriately. [AR 339.] The results of a mental status examination were normal, but plaintiff's mood and affect were anxious. He appeared to be of average intelligence, and his memory was intact. His insight, judgment, and "fund of knowledge w[ere] grossly intact." [AR 340-341.]

Based on his examination of plaintiff, Dr. Nicholson concluded that plaintiff is able to understand, remember, and carry out simple one or two-step job instructions as well as detailed and complex instructions. [AR 341.] In addition, Dr. Nicholson concluded plaintiff has an unlimited ability to accept instructions from a supervisor and perform work activities without special supervision. [AR 342.] However, his ability to relate and interact with co-workers and the public and his ability to maintain concentration, attention, persistence, and pace are "mildly limited." [AR 341.] His ability to maintain regular attendance was also "mildly limited." [AR 342.]

On April 10, 2012, at the request of the Department of Social Services in connection with plaintiff's disability claim, plaintiff had x-rays and an orthopedic consultation, which resulted in written reports by T. Divakaran, M.D., a Radiologist, and Thomas J. Sabourin, M.D., a Board Certified Orthopedic Surgeon. [AR 344-349.] Dr. Divakaran's Radiology Report concludes as follows with respect to plaintiff's left elbow: "Internal fixation plate and screws in the proximal ulna with healed fracture. Post-traumatic osteoarthritis of the elbow joint." [AR 349.] With respect to plaintiff's right knee/leg, the Radiology Report concludes as follows: "Internal fixation plate and screws in the proximal tibia with healed fracture which appears to have extended into the lateral tibial plateau." [AR 349.]

Dr. Sabourin's report states that plaintiff "took a bike and bus to the evaluation today." [AR 344.] Plaintiff reported pain in his left elbow and right knee as a result of "three significant bicycle accidents" which resulted in injuries to his right knee and left

elbow that both needed surgical repair. [AR 344.] He said his right knee is painful when he walks and his elbow is doing "relatively well," but he "gets some pain" after typing more than 20 minutes. [AR 344.] He was not receiving any medical treatment or using assistance devices for these problems. [AR 344.] Dr. Sabourin completed a physical examination and reported that plaintiff "sits and stands with normal posture;" "sits comfortably during the examination;" "rises from a chair without difficulty;" "has no assistance devices;" and has a normal gait and toe heel walking. [AR 345.] Dr. Sabourin also noted that plaintiff had a normal range of motion in his spine, hips, shoulders, wrists, hands, fingers, ankles, and feet. [AR 346-347.] A neurological examination was also normal except for some decreased sensation near the surgical scar on plaintiff's right leg. [AR 347.] However, Dr. Sabourin's report states that: "There is a 2+ varus instability in the right knee. He has some tenderness over the medial aspect of the right knee. There is no redness, swelling, or gross effusion and there is no significant crepitus. He has a varus deformity in the right knee." [AR 346.] Dr. Sabourin also reviewed the x-rays that were taken on the day of the appointment. [AR 347.]

Based on his examination, Dr. Sabourin concluded that plaintiff does have "problems with his right knee and left elbow." [AR 348.] Dr. Sabourin's report also states that: "The left elbow is not too significant [of a] problem. He seems to be getting by with it quite well. The right knee, however, is significant and I feel it does give him significant limitations." [AR 348.] As a result, Dr. Sabourin concluded as follows:

> I feel he could only lift and carry 20 pounds occasionally and 10 pounds frequently with this knee. He could stand and walk up to two hours in an eight-hour workday and sit for six hours in an eight-hour workday. Push and pull limitations will be equal to lift and carry limitations. He is unable to walk on uneven terrain with that knee. He could climb, kneel and crouch only occasionally with that knee. His left elbow is doing well enough that I do not feel he has any significant manipulative limitations, but he could do gross manipulation such as handling, torqu[e]ing, and grasping with the left elbow only frequently. He does not use any assistive devices.

[AR 348.]

During an appointment at Family Health Centers of San Diego on February 22, 2013, plaintiff complained of chronic pain in his right knee and left elbow, and x-rays were ordered. [AR 364-365.] X-rays were completed on April 3, 2013 and were reviewed by Derrick Allen, M.D., who prepared a detailed report of his findings. As to plaintiff's right knee, Dr. Allen's x-ray findings and conclusion state as follows:

1. Intact orthopedic side plate [within the] lateral tibial plateau. Marked irregularity involving the articular surface of the tibial plateau.
2. Moderate size joint effusion.
3. Moderate to severe patellofemoral degenerative change.

[AR 392.]

As to plaintiff's elbow, Dr. Allen's findings and conclusions for the x-rays completed on April 3, 2013 state as follows:

> FINDINGS:
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> Posterior olecranon plate is in place. There is a 2 mm lucency between the plate and the posterior aspect of the olecranon. No definite lucency surrounding the screws. Triangular-shaped density projects adjacent to the radial head near the capitellum on the oblique view which could potentially be a loose body within the joint space. No definite acute fracture line is identified. Well-corticated tiny osseous fragment adjacent to the radial head is also likely sequelae of prior trauma. Irregularity of the radial notch of the ulna is likely sequela of old trauma. . . .
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> CONCLUSION:
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> 1. Olecranon orthopedic plate as described above.
> 2. Triangular osseous density between the radial head and capitellum could potentially represent a loose body. This finding is only appreciable on the oblique view. Correlation with any prior radiographs would be of benefit. CT scan may also be beneficial.
> 3. No acute fracture line or evidence of joint effusion.

[AR 393.]

As a result of the x-rays completed on April 3, 2013, Family Health Centers of San Diego referred plaintiff to an orthopedic surgeon for a consultation. [AR 362-363, 359-360.] At his next appointment at Family Health Centers of San Diego on October 15,

2013, plaintiff indicated he did not know the results of his orthopedic consultation [AR 357], and the results do not appear to be a part of the Administrative Record. At this time, plaintiff was taking medication to control high blood pressure, but there is nothing to indicate he was taking any medication for chronic pain in his knee or elbow. [AR 357-358.]

On August 1, 2013, plaintiff had an appointment with Joel J. Smith, M.D., for a disability evaluation based on his prior right knee and left elbow injuries.[7] [AR 398.] At this time, plaintiff complained of moderate to severe burning pain in his right knee which varied from day to day. [AR 398.] Dr. Smith did acknowledge in the assessment section of his report that plaintiff suffered from joint pain. However, the results of his examination were within normal ranges. [AR 398-399.] With respect to plaintiff's left elbow, Dr. Smith noted that there were "no deformities of misalignment of bones," "no swelling," and no "signs of muscle atrophy." [AR 398.] Dr. Smith also noted as follows: "The carrying angle of the lower arms is symmetrical. The bony landmarks of the two elbows are aligned." [AR 399.] "Range of motion testing of the elbow reveals no restriction or instability related to ligamentous laxity." [AR 399.] "Range of motion in flexion is approximately 130 degrees." [AR 399.] "Range of motion in extension is approximately 30 degrees." [AR 399.]

With respect to plaintiff's right knee, Dr. Smith's report states as follows: "The alignment of the knee and patella are normal; there is no varus or valgus[8] [mis]alignment of the knee or rotational [mis]alignment of the patella." [AR 399.] "Range of motion testing of the knee reveals no restriction or instability related to ligamentous laxity." [AR

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[7] The record indicates that Dr. Smith's disability evaluation was added to the record as "additional evidence" on January 22, 2014, shortly after the December 11, 2013 hearing before the ALJ. [AR 277-278.]

[8] "Valgus" means "of, relating to, or being a deformity in which an anatomical part is turned outward away from the midline of the body to an abnormal degree." Merriam-Webster Dictionary, http://www.merriam-webster.com/dictionary/valgus.

399.] "Strength testing of the major motor muscles of the knee is graded at 5/5." [AR 399.]

C. Administrative Hearing Held on December 11, 2013.

Plaintiff was represented by counsel at the hearing on December 11, 2013. [AR 29.] At the outset of the hearing, the ALJ stated on the record that plaintiff's "date last insured for disability insurance purpose[s] is September 30, 2007." [AR 29.]

1. Plaintiff.

Plaintiff testified that he was fifty-four years old and had attended college. Although he went to college long enough to obtain an Associate Degree, he said he "didn't collect the degree" even though he "did all of the work for it." [AR 30.] Over the past ten to eleven years, plaintiff said he had been living in rental property owned by his parents and received "general relief and food stamps." [AR 31.] He had also recently been approved for health insurance through Medicare or MediCal. [AR 31.]

Plaintiff confirmed that he previously worked as a clerk in a medical office, where he did some typing and filing. He also had to move file boxes when they were ready to be placed in storage. He said he stopped working at this job when he was injured and could not return to this job because he was unable to lift boxes or stay on his feet. He also said he is unable to sit for an eight-hour job because his leg stiffens and he has to get up every few hours. It also takes him a long time to get up and he can then stand for about 10 or 15 minutes. [AR 34-35, 37.] Prior to working as a clerk in a medical office, plaintiff testified that he repaired laser printers and computers. [AR 34.]

Plaintiff testified he was taking medication to control his blood pressure, but when asked if he was taking pain medications, he replied, "I avoid them like the plague." [AR 35.] Plaintiff further testified that he lives alone and is able to do his own grocery shopping. He does not drive but uses buses for transportation. When using the bus system, plaintiff gets on the bus "downhill" from his home and gets off the bus "uphill" from his home, because uphill riding causes pain. On level surfaces, he can ride his bicycle. He also uses the bicycle as a walker when he goes to the grocery store and he

puts the groceries in a basket on the handlebars. [AR 36-37.] Because his right leg is "unstable," plaintiff testified that he loses his balance on a daily basis and has trouble with bathing, shower, and getting dressed. [AR 39-40.]

According to plaintiff, he must limit his errands. He can do two errands in one day, but if he does two errands on three days in a row, he will be unable to walk for a day or two and must scoot around on the carpet inside his home to get from place to place. [AR 37-38.] When he is not out doing errands, plaintiff testified he usually sits or reclines with his leg elevated and does digital painting on a computer using one hand and no keyboard. [AR 38.]

Plaintiff also testified he developed Tourette syndrome when he stopped taking pain medications in 2003. Initially, he had five to seven episodes a day, but they began to taper off in 2010 and it has been a few months since his last episode. [AR 41-42.]

In addition, plaintiff testified that his left arm, which previously required surgery, begins to hurt after typing for five or ten minutes. The pain feels like the "nerve kind of damage" he has experienced in his knee and he has to stop after 15 minutes when using his arm for fine motor skills, such as typing. [AR 48.] When he needs to lift something that weighs 10 to 15 pounds, plaintiff said he has to "favor the other arm." [AR 49.] In other words, he is right handed, so his right hand and arm bear the weight and he uses his left hand as a guide. [AR 49.]

2. Medical Expert – Anthony E. Francis, M.D.[9]

In preparation for his testimony, Dr. Francis reviewed medical records submitted in support of plaintiff's disability claim through and including April 3, 2013. At this time, Dr. Smith's disability evaluation from August 1, 2013 was not in the record. [AR 42,

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[9] According to his *Curriculum Vitae*, Dr. Francis is experienced in orthopedic surgery and emergency medicine. He also has an extensive educational history in medicine, as well as a Juris Doctorate and a Legum Doctorate with emphasis in legal medicine. [AR 171.]

277-278.] Based on the record, Dr. Francis testified plaintiff had several musculoskeletal "pathologies or traumas" and a "tic disorder" (*i.e.*, Tourette syndrome). [AR 42.] Based on plaintiff's testimony, Dr. Francis noted that the tic disorder was "getting better." [AR 43.] With respect to plaintiff's musculoskeletal traumas, Dr. Francis testified there was insufficient evidence to conclude plaintiff's condition would meet or equal a listing prior to the date he was last insured (*i.e.*, September 30, 2007) or thereafter. [AR 42-44.] Referring to Listing 1.02A,[10] Dr. Francis reasoned there was some evidence that plaintiff suffered from degenerative arthritis, which can develop after the type of fracture he had in his leg in 2002. In addition, there was evidence to indicate plaintiff had "dysfunction of a major weight-bearing joint" (*i.e.*, his knee). [AR 44.] However, there was insufficient evidence in the record to indicate plaintiff was "unable to ambulate effectively." [AR 44.] With respect to plaintiff's elbow fracture, Dr. Francis testified:

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[10] Listing 1.02, Major Dysfunction of a Joint: "Characterized by gross anatomical deformity (*e.g.*, subluxation, contracture, bony or fibrous ankylosis, instability) and chronic joint pain and stiffness with signs of limitation of motion or other abnormal motion of the affected joint(s), and findings on appropriate medically acceptable imaging of a joint space narrowing, bony destruction, or ankylosis of the affected joint(s). With: A. Involvement of one major peripheral weight-bearing joint (*i.e.*, hip, knee, or ankle), resulting in inability to ambulate effectively as defined in 1.00B2b; or B. Involvement of one major peripheral joint in each upper extremity (*i.e.*, shoulder, elbow, or wrist-hand), resulting in inability to perform fine and gross movements effectively, as defined in 1.00B2c." 20 C.F.R. Part 404, Subpart P, Appendix 1, Listing 1.02. "Inability to ambulate effectively means an extreme limitation of the ability to walk; *i.e.*, an impairment(s) that interferes very seriously with the individual's ability to independently initiate, sustain, or complete activities. Ineffective ambulation is defined generally as having insufficient lower extremity functioning (see 1.00J) to permit independent ambulation with the use of a hand-held assistive device(s) that limits the functioning of both upper extremities. . . ." 20 C.F.R. Part 404, Subpart P, Appendix 1, Listing 1.00B2b(1). "To ambulate effectively, individuals must be capable of sustaining a reasonable walking pace over a sufficient distance to be able to carry out activities of daily living. They must have the ability to travel without companion assistance to and from a place of employment or school. . . ." 20 C.F.R. Part 404, Subpart P, Appendix 1, Listing 1.00B2b(2).

"[I]t looks like that was handled well" and "I didn't see a lot of problems after that. So I don't know if that led to any significant impairment." [AR 45.]

Based on his review of all of the available records, Dr. Francis testified he was unable to locate evidence indicating plaintiff's residual functional capacity to work was "less than sedentary" prior to his date last insured or at any other time, with the exception of the times he needed to recuperate from fractures. [AR 45-46.] Dr. Francis also commented that results were missing for an orthopedic consultation that was completed sometime after the most recent x-rays of April 3, 2013. [AR 45, referring to AR 357-363.] However, he did not believe these results would make a difference to his analysis. [AR 45.]

3. ***Vocational Expert Bonnie Sinclair, M.S., C.R.C.***[11]

On a Work History form, plaintiff indicated he worked as "clerk" in a medical office from 1980 to August 2002. [AR 209.] He described this job as follows: "Transcribe and type Dr.'s voice record of medical files, file & retrieve said files. Some phone work." [AR 210, 47.] He also indicated he was required to lift and carry "boxes of expired files for disposal weighing approx. 20 to 30 lbs, about twice a month or so." [AR 210, 47.]

Ms. Sinclair testified that plaintiff's past relevant work as a stenographer/ transcriber is generally considered "skilled sedentary work" and requires a person to sit six to seven hours per day to write, type, or handle small objects. [AR 46-47.] However, the particular job that plaintiff previously held fits in the category of light work, because he was required to lift file boxes weighing 20 to 30 pounds about twice per month. On

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[11] According to her Curriculum Vitae, Ms. Sinclair has a Master of Science Degree in Vocational Rehabilitation Counseling. She has many years of experience in this field and also has a number of other credentials in the area of vocational rehabilitation and counseling. [AR 167-169.]

the other hand, it was Ms. Sinclair's view that this type of job would no longer require lifting of file boxes because of advancements in electronics. [AR 46-47.]

Plaintiff's counsel asked Ms. Sinclair if an individual who was only able to perform fine motor movements 50 percent of the day would be able to perform the job of transcriber. Ms. Sinclair responded that the job of transcriber requires reaching, handling, and fingering frequently (*i.e.*, between 33 and 66 percent of the work day). Therefore, it "would be cutting it a little close" for a person to do this job if he could only perform fine motor skills for 50 percent of the day. [AR 50.] Such a person would be able to do the job if it did not require "constant" transcribing. [AR 50.] However, Ms. Sinclair further testified that that such an individual would be unable to sustain the job of transcriber if he missed four or more days of work per month because of pain limitations. [AR 50-51.]

V. ***Insured Status Requirements.***

Plaintiff claimed he was disabled beginning on August 10, 2002 and did not file his application for disability benefits until December 9, 2011. The ALJ therefore considered whether plaintiff met the insured status requirements under the Social Security Act and made the following finding: "The claimant's earnings record shows that the claimant has acquired sufficient quarters of coverage to remain insured through September 30, 2007. Thus, the claimant must establish disability on or before that date in order to be entitled to a period of disability and disability insurance benefits."[12] [AR 13.] Plaintiff does not challenge this finding.

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[12] *See, e.g., Johnson v. Shalala*, 60 F.3d 1428, 1432 (9th Cir. 1995) (stating that the claimant "must prove that [he or] she was either permanently disabled or subject to a condition which became so severe as to disable her prior to the date upon which her disability insured status expires.")

VI. The ALJ's Five-Step Disability Analysis.

To qualify for disability benefits under the SSA, an applicant must show that he or she is unable to engage in any substantial gainful activity because of a medically determinable physical or mental impairment that has lasted or can be expected to last at least 12 months. 42 U.S.C. § 423(d). The Social Security regulations establish a five-step sequential evaluation for determining whether an applicant is disabled under this standard. 20 C.F.R. § 404.1520(a); *Tackett v. Apfel*, 180 F.3d 1094, 1098 (9th Cir. 1999).

At step one, the ALJ must determine whether the applicant is engaged in substantial gainful activity. 20 C.F.R. § 404.1520(a)(4)(I). In this case, the ALJ concluded that plaintiff had not engaged in substantial gain activity since August 10, 2002, the date he alleged his disability began. [AR 15.]

At step two, the ALJ must determine whether the applicant is suffering from a "severe" impairment within the meaning of Social Security regulations from the date he was last insured. 20 C.F.R. § 404.1520(a)(4)(ii). "An impairment or combination of impairments is not severe if it does not significantly limit [the applicant's] physical or mental ability to do basic work activities." 20 C.F.R. § 404.1521(a). For example, a slight abnormality or combination of slight abnormalities that only have a minimal effect on the applicant's ability to perform basic work activities will not be considered a "severe" impairment. *Webb v. Barnhart*, 433 F.3d 683, 686 (9th Cir. 2005). Examples of basic work activities include walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, handling, seeing, hearing, speaking, understanding, carrying out and remembering simple instructions, use of judgment, responding appropriately to supervision, co-workers and usual work situations, and dealing with changes in a routine work setting. 20 C.F.R. § 404.1521(b)(1)-(6). "If the ALJ finds that the claimant lacks a medically severe impairment, the ALJ must find the claimant not to be disabled." *Webb v. Barnhart*, 433 F.3d at 686.

Here, the ALJ found at step two that plaintiff had severe impairments, including a "Tic disorder/Tourette's Syndrome;" "status post" reconstruction of his right knee;

"status post" fracture of his left elbow; "residual medial instability of the right knee;" and "moderate degenerative joint disease of the right knee." [AR 15-16.] Although the ALJ acknowledged there was evidence in the record indicating plaintiff suffered from anxiety, the ALJ concluded it was "non-severe," because it did not "cause more than minimal limitation in [his] ability to perform basic mental work activities." [AR 16.]

If there is a severe impairment, the ALJ must then determine at step three whether it meets or equals one of the listings of impairments in the Social Security regulations. 20 C.F.R. § 404.1520(a)(4)(iii). If the applicant's impairment meets or equals a listing, he or she must be found disabled. *Id.*

In this case, the ALJ concluded at step three that plaintiff does not have an impairment or combination of impairments that meets or medically equals the severity of one of the listed impairments in 20 C.F.R. Part 404, Subpart P, Appendix 1. [AR 17.] The ALJ reasoned that the testifying medical expert and state agency physicians opined that plaintiff's medical condition does not meet or equal a listing and no treating or examining physician made findings that would satisfy the severity requirements in the Listing of Impairments. [AR 17.]

If an impairment does not meet or equal a listing, the ALJ must make a step four determination of the claimant's residual functional capacity based on all impairments, including impairments that are not severe. 20 C.F.R. § 404.1520(e), § 404.1545(a)(2). "Residual functional capacity" is "the most [an applicant] can still do despite [his or her] limitations." 20 C.F.R. § 404.1545(a)(1). The ALJ must determine whether the applicant retains the residual functional capacity to perform his or her past relevant work. 20 C.F.R. § 404.1520(a)(4)(iv). The ALJ's determination is made "based on all the relevant medical and other evidence in [the claimant's] case record." 20 C.F.R. § 404.1520(e). A claimant is not disabled if he or she can still do his or her past relevant work. 20 C.F.R. § 404.1520(a)(4)(iv).

Here, the ALJ concluded plaintiff does not qualify for disability benefits, because he has the residual functional capacity to perform a full range of sedentary work. [AR

17-22.] According to the ALJ, plaintiff is able to perform his past relevant work as a stenographer/transcriber, which is considered skilled sedentary work as it is performed in the national economy, because he can lift and carry ten pounds, and sit, walk, or stand for six hours in an eight-hour workday. [AR 21-22.] In reaching this conclusion, the ALJ discredited plaintiff's testimony indicating he could not perform sedentary work because of disabling pain in his left arm and right leg. [AR 20-22.][13]

VII. Discussion.

A. The Parties' Cross-Motions for Summary Judgment.

In his Motion for Summary Judgment, plaintiff attempts to enlarge and embellish the testimony he gave at the hearing before the ALJ to convince the Court that the ALJ's denial of his disability claim is erroneous, because he has long suffered from disabling pain caused by injuries and severe deformities in his knee and elbow [Doc. No. 32, at pp. 1-25] and from a disabling mental illness (Tourette syndrome) that renders him unable "to function or discern reality." [Doc. No. 32, at p. 28.] However, the Court is unable to consider additional testimony or evidence that was not presented at the hearing before the ALJ. "In the context of judicial review of a decision of the Commissioner regarding SSI disability benefits, evidence outside the administrative record generally is precluded from consideration by the court." *Baker v. Barnhart*, 457 F.3d 882, 891 (8th Cir. 2006).

Plaintiff's Motion for Summary Judgment also attacks the written medical opinions in the record for various reasons, such as the doctors' alleged failure to ask him any questions about pain. [Doc. No. 32, at p. 4-5.] However, in *Meanel v. Apfel*, 172 F.3d 1111 (9th Cir.1999), the Ninth Circuit explained that "appellants must raise issues at their administrative hearings in order to preserve them on appeal." *Id.* at 1115. Plaintiff

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[13] Since the ALJ concluded plaintiff was not disabled at step four, he did not reach step five of the disability analysis, which requires a determination as to whether the applicant can perform any other work in the national economy. 20 C.F.R. § 404.1520(a)(4)(g),(v); 20 C.F.R. § 404.1545(e); 20 C.F.R. § 416.929.

was represented by counsel at the hearing before the ALJ. Through his counsel, plaintiff did not object to the state of the record or to any of the challenged physician reports. As a result, plaintiff waived any argument that the reports by these physicians are deficient in any significant manner. It is therefore RECOMMENDED that the District Court DENY plaintiff's Motion for Summary Judgment, because he has not shown that the ALJ's decision to deny benefits is not supported by substantial evidence or that the ALJ failed to apply the correct legal standards.

Defendant argues that the ALJ's decision to deny plaintiff's disability claim should be affirmed, because substantial evidence supports the ALJ's determination that plaintiff was not disabled on or before September 30, 2007, his date last insured. Defendant also argues that the ALJ's decision should be affirmed, because it is free from legal error. [Doc. No. 26-1.]

As noted above, the final decision of the Commissioner must be affirmed if it is supported by substantial evidence and if the Commissioner has applied the correct legal standards. *Batson v. Comm'r of the Social Security Admin.*, 359 F.3d at 1193. Based on a careful review of the record, it is this Court's view that the ALJ's decision is supported by substantial evidence. First, the ALJ's decision that plaintiff has the residual functional capacity for sedentary work is supported by the treatment records and the opinions of several medical professionals, including treating and examining physicians, and the testifying medical expert, all of which are summarized above. There is no objective medical evidence in the record to support a conclusion that plaintiff qualifies for disability benefits, because he suffered a disability under the SSA on or before September 30, 2007, his date last insured.

Second, the ALJ appropriately rejected plaintiff's testimony that he is unable to work at a sedentary job because he suffers from disabling pain. In *Light v. Social Security Administration*, 119 F.3d 789 (9th Cir. 1997), the Ninth Circuit held that an ALJ cannot discredit or reject subjective claims of "excess pain" based solely on a lack of objective medical support in the record. *Id.* at 792-793. "In assessing the credibility of a

claimant's testimony regarding subjective pain or the intensity of symptoms, the ALJ engages in a two-step analysis. [Citation omitted.] First, the ALJ must determine whether there is 'objective medical evidence of an underlying impairment which could reasonably be expected to produce the pain or other symptoms alleged.' [Citations omitted.] If the claimant has presented such evidence, and there is no evidence of malingering, then the ALJ must give 'specific, clear and convincing reasons' in order to reject the claimant's testimony about the severity of the symptoms. [Citations omitted.] At the same time, the ALJ is not 'required to believe every allegation of disabling pain, or else disability benefits would be available for the asking, a result plainly contrary to 42 U.S.C. § 423(d)(5)(A).' [Citation omitted.] In evaluating the claimant's testimony, the ALJ may use 'ordinary techniques of credibility evaluation.' [Citation omitted.] For instance, the ALJ may consider inconsistencies either in the claimant's testimony or between the testimony and the claimant's conduct, [such as] . . . 'whether the claimant engages in daily activities inconsistent with the alleged symptoms.' [Citation omitted.] While a claimant need not 'vegetate in a dark room' in order to be eligible for benefits, [citation omitted], the ALJ may discredit a claimant's testimony when the claimant reports participation in everyday activities indicating capacities that are transferable to a work setting. [Citation omitted.] Even where those activities suggest some difficulty functioning, they may be grounds for discrediting the claimant's testimony to the extent that they contradict claims of a totally debilitating impairment. [Citation omitted.]" *Molina v. Astrue*, 674 F.3d 1104, 1112-1113 (9th Cir. 2012

Under Social Security regulations, factors to be considered in evaluating the intensity, persistence, and limiting effects of a claimant's symptoms include: (i) daily activities; (ii) the location, duration, frequency, and intensity of pain or other symptoms; (iii) precipitating and aggravating factors; (iv) the type, dosage, effectiveness, and side effects of any medication taken to alleviate pain or other symptoms; (v) treatment to relieve pain or symptoms other than medication; (vi) any measures used to relieve pain or other symptoms (*e.g.*, lying flat, standing for 15 to 20 minutes every hour, sleeping on a

board, etc.); and (vii) functional limitations and restrictions due to pain or other symptoms. 20 C.F.R. § 404.1529(c)(3); 20 C.F.R. § 416.929(c)(3); Social Security Regulation 16-3p.

"A finding that a claimant's testimony is not credible 'must be sufficiently specific to allow a reviewing court to conclude the adjudicator rejected the claimant's testimony on permissible grounds and did not arbitrarily discredit a claimant's testimony regarding pain.' [Citation omitted.] General findings are insufficient; rather, the ALJ must identify what testimony is not credible and what evidence undermines the claimant's complaints. [Citation omitted.]" *Brown-Hunter v. Colvin*, 806 F.3d 487, 493 (9th Cir. 2015). The Court is "constrained to review the reasons the ALJ asserts." *Brown-Hunter*, 806 F.3d at 492. On the other hand, "there is no rigid requirement that the ALJ specifically refer to every piece of evidence in his decision." *Reid v. Comm'r of Social Sec.*, 769 F.3d 861, 865 (4th Cir. 2014), quoting *Dyer v. Barnhart*, 395 F.3d 1206, 1211 (11th Cir. 2005).

Here, the ALJ acknowledged the existence of objective evidence indicating plaintiff has impairments that could reasonably be expected to produce the alleged symptoms. However, based on the evidence submitted, the ALJ concluded that plaintiff's "statements concerning the intensity, persistence, and limiting effects of these symptoms are not entirely credible for the reasons explained in this decision." [AR 25.] The ALJ stated several reasons for this conclusion, each of which is discussed separately below.

1. Lack of Objective Medical Evidence.

The ALJ's first reason for rejecting plaintiff's testimony is that the objective medical evidence does not show that plaintiff's symptoms are frequent or severe enough to significantly interfere with his ability to work. [AR 20.] In support of this reason, the ALJ cited substantial objective evidence in the record. For example, the ALJ noted that neurological examinations "have revealed no significant focal deficits." [AR 20.] Plaintiff's medical records show he can walk in a satisfactory manner and there is nothing to indicate he suffers from muscle weakness, loss of muscle control, muscle atrophy, or

wasting in the arms and legs due to nerve damage. [AR 20.] Treating source opinions indicate plaintiff "experienced excellent results postoperatively." [AR 21.] Other physicians who examined plaintiff and/or reviewed his medical records have concluded he remains capable of performing full time work on a sustained basis. [AR 21.] The ALJ gave these opinions significant weight, because they contain detailed clinical findings and narratives explaining and supporting the medical opinions. [AR 21.] However, as noted above, an ALJ cannot "reject a claimant's subjective complaints based solely on a lack of medical evidence to fully corroborate the alleged severity of pain." *Burch v. Barnhart* (9th Cir. 2005) 400 F.3d 676, 680 (9th Cir. 2005). As a result, the ALJ's first reason, standing alone, is not enough to discredit plaintiff's testimony that he is totally disabled by pain and inability to ambulate effectively.

2. Conservative Course of Treatment.

The ALJ's next reason for rejecting plaintiff's testimony is that the record indicates he had only conservative care for his elbow and knee following surgery and recovery. More specifically, the record indicates plaintiff did take medications postoperatively, and they were effective in controlling his pain. Following recovery, the record indicates plaintiff's was not taking medication to control pain in his arm or leg. [AR 20.] The Court notes also that when asked during the hearing whether he was taking pain medications, plaintiff replied, "I avoid them like the plague." [AR 35.]

"Impairments that can be controlled effectively with medication are not disabling." *Warre v. Commissioner of Social Sec. Admin.*, 439 F.3d 1001, 1006 (9th Cir. 2006). Evidence of "conservative treatment" can be sufficient to discredit a claimant's testimony about the severity of an impairment. *Johnson v. Shalala*, 60 F.3d 1428, 1434 (9th Cir. 1995). For example, "over-the-counter pain medication" is considered "conservative treatment" that is sufficient to discount a claimant's testimony. *Parra v. Astrue*, 481 F.3d 742, 751 (9th Cir. 2007). An ALJ may also infer that a claimant's "response to conservative treatment undermines [his] reports regarding the disabling nature of his pain." *Tommasetti v. Astrue*, 533 F.3d 1034, 1039-1040 (9th Cir. 2008).

As noted above, the ALJ may use "ordinary techniques of credibility evaluation." *Molina v. Astrue*, 674 F.3d at 1112-1113. The ALJ is also entitled to draw inferences "logically flowing from the evidence." *Macri v. Chater*, 93 F.3d 540, 544 (9th Cir. 1996). On the record before the Court, the ALJ could reasonably discount plaintiff's claims of disabling pain, because the record indicates he was not taking any medications to treat his alleged disabling pain after he recovered from the surgeries on his left elbow and right knee. [AR 344, 357-358, 377.] Thus, it is this Court's view that the ALJ has stated a clear and convincing reason for discrediting plaintiff's testimony that he is totally disabled by pain.

3. Physical Limitations and Special Accommodations.

The ALJ's third reason for rejecting plaintiff's testimony is that the record does not show plaintiff suffered from any physical limitations indicative of a total disability or that he required any special accommodations (*e.g.*, special breaks or positions) to relieve his pain. For example, the ALJ noted plaintiff did not exhibit any significant atrophy, loss of strength, or difficulty moving that are indicative of severe and disabling pain. Although he alleged loss of balance, he had a normal gait and did not require any assistive devices to ambulate. [AR 26-27.]

The ALJ's conclusions in this regard are supported by substantial evidence in the record. First, Dr. Sabourin, who completed an orthopedic examination of plaintiff on April 10, 2012, stated in his written report that plaintiff has a normal gait, normal posture, and normal "[t]oe heel walking." [AR 345.] He also reported that plaintiff did not have any assistance devices, has a relatively normal range of motion, and could rise from a chair without difficulty. [AR 345-346.] Dr. Sabourin did acknowledge that plaintiff has some problems with his right knee and left elbow, but concluded he did not have "any significant manipulative limitations" in his left elbow and could "walk up to two hours in an eight-hour workday" and "lift and carry 20 pounds occasionally and 10 pounds frequently with this knee." [AR 348.] Similar results were expressed by Dr. Smith, who examined plaintiff on August 1, 2013. Dr. Smith's report states that plaintiff did not have

any swelling or signs of muscle atrophy and had normal strength and range of motion. [AR 398-399.] It is true that plaintiff testified he uses his bicycle as a walker when he does his grocery shopping [AR 36-37], but there is no evidence in the record to indicate he needed or used any medically prescribed assistive devices to ambulate. Thus, it is this Court's view that the ALJ has stated a clear and convincing reason for discrediting plaintiff's testimony that he is totally disabled by pain.

4. Routine Daily Activities.

The ALJ's decision further states as follows: "Additionally, there is no indication in the evidence of record that the claimant is unable to attend to routine daily activities. Moreover, the claimant's routine activities establish a level of functioning greater than that alleged. The claimant's activities of daily living include the ability to cook his own meals and do laundry. He is able to go out alone and he can handle bills and handle cash appropriately without assistance." [AR 21.] This evidence about plaintiff's daily activities is from a report prepared by Dr. Nicholson, the Board Certified Psychiatrist who examined plaintiff on April 2, 2012. [AR 337-342.]

In addition to the daily activity information in Dr. Nicholson's report, plaintiff testified at the hearing that he is able to use buses for transportation to do errands, can ride his bicycle on level surfaces, and do his grocery shopping while using his bicycle as a walker and the basket on his bicycle as grocery carrier. [AR 36-37.]

"While a claimant need not 'vegetate in a dark room' in order to be eligible for benefits, the ALJ may discredit a claimant's testimony when the claimant reports participation in everyday activities indicating capacities that are transferable to a work setting. Even where those activities suggest some difficulty functioning, they may be grounds for discrediting the claimant's testimony to the extent that they contradict claims of a totally debilitating impairment. *Molina v. Astrue*, 674 F.3d 1104, 1112-13 (9th Cir. 2012).

A claimant's "daily activities" is one of the factors that may be considered by an ALJ in evaluating the credibility of a claimant's testimony about the extent of his or her

pain or impairment. *Orn v. Astrue*, 495 F.3d 625, 636 (9th Cir. 2007). However, the ALJ may not discredit a claimant's testimony about the extent of his or her pain and impairment based solely on "daily activities, such as grocery shopping, driving a car, or limited walking for exercise." *Vertigan v. Halter*, 260 F.3d 1044, 1050 (9th Cir. 2001). An ALJ may reject a claimant's testimony about the extent of his or her pain or impairment if "'a claimant is able to spend a substantial part of [the] day engaged in pursuits involving the performance of physical functions that are transferable to a work setting.'" *Orn*, 495 F.3d at 639 (internal citation omitted).

Although plaintiff did testify that his daily activities are significantly limited by pain in his arm and knee, the ALJ had reason to question this testimony based on Dr. Nicholson's report and the other credibility factors discussed above. It is true that the evidence about plaintiff's daily activities, standing alone, is not enough to discredit his testimony that he is disabled by pain. However, this evidences does lend some support to the ALJ's decision to reject plaintiff's testimony that he suffers from disabling pain.

Based on the foregoing, it is this Court's view that the ALJ's decision denying plaintiff's claim for disability benefits is supported by specific, clear, and convincing reasons for rejecting plaintiff's testimony about the severity of his pain. In addition, it is also this Court's view that the ALJ's decision to deny disability benefits is supported by substantial evidence and free from legal error.

B. Plaintiff's Motion to Exclude Evidence [Doc. No. 30].

In his Motion to Exclude Evidence [Doc. No. 30], plaintiff argues that the Court should exclude the "expert testimony" of the following non-treating, examining physicians for "failure to meet the *Daubert* standard": [Doc. No. 30, at p. 1.] (1) Dr. Nicholson, M.D.; (2) Dr. Sabourin, M.D.; and (3) Dr. Smith, M.D. [Doc. No. 30, at p. 1.] As outlined more fully above, Dr. Nicholson is a Board Certified Psychiatrist, who completed a consultative examination of plaintiff on April 2, 2012 and prepared a written report. [AR 337-342.] Dr. Sabourin is a Board Certified Orthopedic Surgeon who examined plaintiff on April 10, 2012 and prepared a written report. [AR 344-349.]

Dr. Smith, M.D., examined plaintiff on August 1, 2013 and prepared a disability report. [AR 398-399.] None of these physicians testified at plaintiff's hearing.

Essentially, plaintiff argues that the Court should not consider the reports prepared by these physicians, because they failed to adequately address key issues that are relevant to plaintiff's disability claim, and, as a result, they failed "to meet the *Daubert* standard." [Doc. No. 30, at p. 1.] According to plaintiff, Dr. Nicholson's report should be excluded, because he failed to address plaintiff's allegation that he suffers from a mental health condition known as Tourette syndrome. [Doc. No. 30, at p. 1.] With respect to Dr. Sabourin's report, plaintiff argues that it should be excluded because he avoided and failed to discuss "the central issue of pain." [Doc. No. 30, at pp. 1-2.] Finally, plaintiff points to a blank form in the record [AR 396] and argues that Dr. Smith's report should be excluded, because he reported reviewing x-rays but did not fill out the form to obtain any x-rays. Plaintiff believes this is evidence of "false testimony." [Doc. No. 30, at pp. 6-7.] However, plaintiff's argument is nonsensical. A review of the record does not support plaintiff's interpretation of the cited documents, and Dr. Smith's report indicates that his disability evaluation is based on a physical examination of plaintiff without reference to x-rays. [AR 394-399.]

It is this Court's view that plaintiff's Motion to Exclude Evidence should be rejected for at least four reasons. First, plaintiff's reliance on *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579 (1993) is misplaced. "The Federal Rules of Evidence do not apply to the admission of evidence in Social Security administrative proceedings. *See* 42 U.S.C. § 405(b)(1); 20 C.F.R. §§ 404.950(c), 416.1450(c) ('The administrative law judge may receive evidence at the hearing even though the evidence would not be admissible in court under the rules of evidence used by the court.'); *Richardson v. Perales*, 402 U.S. 389, 400, 91 S.Ct. 1420, 28 L.Ed.2d 842 (1971) ('[S]trict rules of evidence, applicable in the courtroom, are not to operate at social security hearings so as to bar the admission of evidence otherwise pertinent....')." *Bayliss v. Barnhart*, 427 F.3d 1211, 1218 (9th Cir. 2005).

Second, in *Meanel v. Apfel*, 172 F.3d 1111 (9th Cir.1999), the Ninth Circuit explained that "appellants must raise issues at their administrative hearings in order to preserve them on appeal." *Id.* at 1115. Plaintiff was represented by counsel at the hearing before the ALJ. Through his counsel, plaintiff did not object to the state of the record or to any of the challenged physician reports. As a result, plaintiff waived any argument that the reports by these physicians are deficient in any significant manner.

Third, as noted above, plaintiff had the burden of proving eligibility at steps one through four of the five-step disability analysis. *Celaya v. Halter*, 332 F.3d at 1180. To the extent he disagreed with the opinions of any of the physicians who examined him in connection with his disability claim, plaintiff could have presented contrary evidence by a treating or other physician but failed to do so.

Finally, even if plaintiff objected to consideration of the challenged reports during the administrative hearing before the ALJ on the grounds stated in his Motion to Exclude Evidence, there is nothing to indicate the ALJ would have sustained any such objection. The challenged reports include relevant, objective medical evidence by three physicians who examined plaintiff and then prepared written reports with clear, detailed explanations for the medical opinions they expressed. As a result, the ALJ was entitled to consider these reports even though they do not say what plaintiff would have liked them to say.

For the foregoing reasons, there is no basis for granting plaintiff's request to exclude reports by Dr. Nicholson, Dr. Sabourin, and Dr. Smith for "failure to meet the *Daubert* standard" [Doc. No. 30, at p. 1] or for any other reason. It is therefore RECOMMENDED that the District Court DENY plaintiff's Motion to Exclude Evidence. [Doc. No. 30.]

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C. Plaintiff's Ex Parte Request to Supplement the Administrative Record [Doc. No. 28].

On November 3, 2016, plaintiff submitted a letter addressed to the Court, which has been construed as a renewed Ex Parte Request to Supplement the Administrative Record.[14] [Doc. No. 28.] In this Ex Parte Request, plaintiff argues that x-ray images material to the ALJ's disability determination were erroneously omitted from the record. According to plaintiff, he only became aware that these x-ray images were omitted when he received a copy of the record for use in this proceeding. The allegedly omitted x-ray images date back as far as his initial injury on August 10, 2002. Plaintiff believes these x-ray images were erroneously omitted from the record even though he took all necessary steps to release all of his medical records for submission in support of his disability claim. [Doc. No. 28, at pp. 1-3.] Plaintiff argues that these x-ray images should have been included in the record all along for review by the ALJ and by this Court, because they show the severity of his injuries. He speculates that a lay person with "an elementary school protractor" would be able to measure "the degree of painful bending in the bones." [Doc. No. 28, at p. 3-4.] In addition, plaintiff contends these x-rays can be compared to show "the progressive and chronic nature" of his injuries. [Doc. No. 28, at p. 4.]

As plaintiff acknowledges, however, the record does include x-ray reports and/or written observations by several physicians who reviewed actual x-ray images. [Doc. No.

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[14] Plaintiff essentially raised the same issue in a prior letter to the Court that was filed on June 17, 2016. [Doc. No. 19.] The Court construed plaintiff's letter as a Motion to Continue to Present New Evidence. [Doc. No. 23.] The letter requested to continue the case so that plaintiff could obtain x-rays "since 2002" because he believed this evidence would show "an inaccurate diagnosis" that affected the outcome of his disability claim. [Doc. No. 23, at p. 1, citing Doc. No. 17, at p. 1.] Plaintiff's letter request was denied without prejudice, because he did not show that this "new evidence" is material or that there was "good cause" for failure to include this evidence in the administrative proceeding. [Doc. No. 23, at pp. 3-4.]

28, at p. 5, referring to the omitted x-rays and stating that "[o]nly written observance is mysteriously included."] For example, the earliest reference to an x-ray in the record was made in treatment notes by Dr. Henderson from August 21, 2002, "ten days" after plaintiff's knee surgery. [AR 320.] Dr. Henderson's treatment notes include a section entitled "X-Rays," which states as follows: "AP and lateral radiographs show good alignment at the fracture site [and] hardware in good position." [AR 326.] As summarized more fully above, the record also includes several other detailed x-ray reports. [*See, e.g.*, AR 392-393.] Dr. Henderson's treatment notes from plaintiff's final follow up appointment on June 18, 2003 do not refer to x-ray images but state that plaintiff "has full flexion, full extension, and there is no effusion in the knee. Clinically, there is just very mild varus compared to the opposite knee which is also at slight varus." [AR 319.] However, when Dr. Sabourin later reviewed x-rays taken on April 10, 2012, he concluded that plaintiff had "a significant varus deformity" in his right knee. [AR 347-348.] As a result, he concluded plaintiff had "problems with his right knee" that required "significant limitations." [AR 348.] Among other limitations, Dr. Sabourin concluded plaintiff could only lift and carry 20 pounds occasionally and 10 pounds frequently because of the condition of his knee. [AR 348.]

"In the context of judicial review of a decision of the Commissioner regarding SSI disability benefits, evidence outside the administrative record generally is precluded from consideration by the court." *Baker v. Barnhart*, 457 F.3d 882, 891 (8th Cir. 2006). In this regard, Title 42, United States Code, Section 405(g), states in pertinent part as follows: "The court shall have power to enter, **upon the pleadings and transcript of the record,** judgment affirming, modifying, or reversing the decision of the Commissioner of Social Security, with or without remanding the cause for rehearing." 42 U.S.C. § 405(g) (emphasis added).

When new evidence that is not part of the administrative record is presented for the first time to the District Court, Section 405(g) allows the District Court to remand the case to the Social Security Administration for consideration if, and only if there is "a

showing" that the new evidence is "material" and that there is "good cause for the failure to incorporate such evidence into the record in a prior proceeding. . . ." 42 U.S.C. § 405(g); *Brewes v. Commissioner of Social Sec. Admin.*, 682 F.3d 1157, 1164 (9th Cir. 2012).

"Good cause" exists if the claimant can provide a reasonable explanation as to why new evidence was unavailable earlier. *Mayes v. Massanari*, 276 F.3d 453, 463 (9th Cir. 2001). For example, "[n]ew medical evidence that becomes available due to improvements in technology meets the good cause standard, and shall be considered if it also meets the materiality requirement." *Wainwright v. Sec'y of Health & Human Servs.*, 939 F.2d 680, 683 (9th Cir. 1991). "A claimant does not meet the good cause requirement by merely obtaining a more favorable report once his or her claim has been denied." *Mayes v. Massanari*, 276 F.3d at 463. Without more, a simple assertion "that the evidence only turned up later" is also not enough to satisfy the "good cause" standard. *Clem v. Sullivan*, 894 F.2d 328, 332 (9th Cir. 1990).

New evidence is "material" if there is a reasonable possibility that it would have changed the outcome of the claim for disability benefits. *Booz v. Sec'y of Health and Human Servs.*, 734 F.2d 1378, 1380-1381 (9th Cir. 1984). The new evidence must be probative of the claimant's condition as it existed during the relevant time period and prior to the disability hearing. *Sanchez v. Sec'y of Health and Human Servs.*, 812 F.2d 509, 511-512 (9th Cir. 1987). New evidence of "later-acquired disabilities or subsequent deterioration of a previously non-disabling condition" are not "material." *Jones v. Callahan*, 122 F.3d 1148, 1154 (8th Cir. 1997). In *Sanchez v. Secretary of Health and Human Services*, 812 F.2d 509, for example, the Ninth Circuit concluded that the claimant's new evidence was not material because "at most, [it showed] deterioration after the hearing, which would be material to a new application but not probative of [the claimant's] condition at the hearing." *Id.* at 512.

Based on the arguments in his Ex Parte Request, plaintiff's position is that there is "good cause" to supplement the record with x-ray images because they were part of the

medical records he released to support his disability claim and should have been included in the record all along. However, if the x-ray images should have been included all along, plaintiff does not explain why his counsel failed to object to the state of the record during the administrative proceedings, particularly when plaintiff had the burden at that time to prove he was disabled. Plaintiff has therefore not shown good cause for failing to include the x-ray images in the record during the administrative proceeding and has waived any argument that the record is deficient because the x-ray reports conflict with the actual x-ray images.

Plaintiff's Ex Parte Request also takes the position that the x-ray images are material to the disability analysis, because the x-ray reports do not accurately portray the extent of post-surgical deformity in his right knee and left elbow which has resulted in disabling pain. Despite plaintiff's speculative argument that a lay person with "an elementary school protractor" would be able to look at the x-ray images and measure "the degree of painful bending in the bones," the x-ray images are not material to the ALJ's disability analysis.

An ALJ is generally "not qualified to interpret raw medical data in functional terms" and must rely on the opinions of qualified medical professionals. *Nguyen v. Chater*, 172 F.3d 31, 35 (1st Cir. 1999). *See also Rivera-Torres. v. Sec. of Health and Human Svcs.*, 837 F.2d 4, 6-7 (1st Cir. 1988) (concluding that "the ALJ, a lay factfinder, lacks sufficient expertise to conclude claimant has the ability to be on his feet all day . . . . Rather, an explanation of claimant's functional capacity from a doctor is needed."); *Berrios v. Sec. of Health and Human Svcs.*, 796 F.2d 574, 576 (1st Cir. 1986) (stating that "[w]e do not think the Appeals Council, composed of lay persons, was competent to interpret and apply . . . raw, technical medical data."); *Day v. Weinberger*, 522 F.2d 1154, 1156 (9th Cir. 1975) (stating that "the Hearing Examiner, who was not qualified as a medical expert, should not have gone outside the record to medical textbooks for the purpose of making his own exploration and assessment as to claimant's physical condition"). More significantly, it would not be appropriate for an ALJ to reject a

physician's assessment of a claimant's ability to work based on his own interpretation of an x-ray. *Naranjo v. Astrue*, 2010 WL 1277974, 151 Soc. Sec.Rep.Serv. 661 (D. Colo. 2010).

Here, the ALJ reached his conclusions about plaintiff's residual functional capacity for sedentary work based on the opinions of medical professionals who were qualified to interpret x-rays of plaintiff's elbow and knee and other pertinent medical data. Thus, even if x-ray images were included in the record, it would not be appropriate for the ALJ to reject the opinions of qualified medical professionals based on his own interpretation of the x-ray images. Under these circumstances, it is not reasonably possible that supplementing the record with x-ray images would have any effect whatsoever on the outcome of plaintiff's disability claim. In other words, the x-ray images are not material to the ALJ's disability analysis. Therefore, IT IS RECOMMENDED that the District Court DENY plaintiff's Ex Parte Request to Supplement the Administrative Record [Doc. No. 28].

VIII. Conclusion.

Based on a thorough review of the Administrative Record, this Court concludes that substantial evidence supports the ALJ's decision that plaintiff does not qualify for disability benefits because he is not disabled and retains the residual functional capacity to perform his past relevant work as a transcriber/stenographer. In addition, the ALJ set forth specific, clear, and convincing reasons for discrediting plaintiff's testimony that he is disabled by pain and did not arbitrarily reject this testimony.

IT IS THEREFORE RECOMMENDED THAT THE DISTRICT COURT:

1. GRANT defendant's Motion for Summary Judgment [Doc. No. 26] and DENY plaintiff's Motion for Summary Judgment [Doc. No. 32];

2. DENY defendant's Motion to Dismiss [Doc. No. 24];

3. DENY plaintiff's Motion to Exclude Evidence [Doc. No. 30]; and

4. DENY plaintiff's Request to Supplement the Record [Doc. No. 28].

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This Report and Recommendation is submitted to the United States District Judge assigned to this case, pursuant to the provisions of 28 U.S.C. § 636(b)(1) and Civil Local Rule 72.1(d). Within fourteen (14) days after being served with a copy of this Report and Recommendation, "any party may serve and file written objections." 28 U.S.C. § 636(b)(1)(B)&(C). The document should be captioned "Objections to Report and Recommendation." The parties are advised that failure to file objections within this specific time may waive the right to raise those objections on appeal of the Court's order. *Martinez v. Ylst*, 951 F.2d 1153, 1156–57 (9th Cir.1991).

IT IS SO ORDERED.

Dated: January 23, 2017

Hon. Karen S. Crawford
United States Magistrate Judge